CM LEE FITNESS CAMP APPLICATION WINTER 2017

ALL INFORMATION MUST BE FILLED OUT COMPLETELY AND MUST BE LEGIBLE

Site: (circle only one) **Blackburn** **Dodge** **Howard**

Total # in family _____ Yearly Income $_____ **(AGI – Adjusted Gross Income from Federal Tax form 1040)**

1. Child resides primarily with: **(circle one) Mother Father Guardian Both**

2. Parent #1 Name: _____ _____ _____
Last **First** **MI**
Address: _____ _____ _____
Number & Street **City** **State** **Zip**
Home Phone (____)_____ **Work Phone (_____)**_____ **Ext.** _____
Cell Phone (_____)_____ **Email** _____

3. Parent #2 Name: _____ _____ _____
Last **First** **MI**
Home Phone (____)_____ Work Phone (_____)_____ Ext. _____
Cell Phone (_____)_____ Email _____

4. Child 1 Name: _____ _____ _____
Last **First** **MI**
Gender: (circle one) Male Female Date of Birth: _____/_____/_____ **Age:** _____

Health Conditions **(circle all that apply)** Speech Impairment Hearing Impairment **Vision Impaired**
Asthma Diabetes Hyperactivity Medications: _____
Allergies: _____ Other Illness: (explain) _____

Ethnicity: (you must check one) Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐

Race: Check All That Apply: African American/Black_____ **White**_____ **Asian**_____ **Alaskan Native**_____ **Amer. Indian**_____
Native Hawaiian/Other Pacific Islander_____ **Other** (fill in)_____

5. Child 2 Name: _____ _____ _____
Last First MI
Gender: (circle one) Male Female **Date of Birth:** _____/_____/_____ Age: _____

Health Conditions (circle all that apply) Speech Impairment Hearing Impairment Vision Impaired
Asthma Diabetes Hyperactivity Medications: _____
Allergies: _____ Other Illness: (explain) _____

Ethnicity: (you must check one) **Hispanic/Latino** ☐ **Non-Hispanic/Non-Latino** ☐

Race: (Check All that Apply): African American/Black_____ White_____ Asian_____ Alaskan Native_____ Amer. Indian_____
Native Hawaiian/Other Pacific Islander_____ Other (fill in) _____

6. Child 3 Name: _____ _____ _____
Last First MI
Gender: (circle one) Male Female **Date of Birth**: _____/_____/_____ **Age**: _____

Health Conditions (circle all that apply) Speech Impairment Hearing Impairment Vision Impaired
Asthma Diabetes Hyperactivity Medications: _____
Allergies: _____ Other Illness: (explain) _____

Ethnicity: (you must check one) Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐

Race: (check All that Apply): **African American/Black**_____ **White**_____ **Asian**_____ **Alaskan Native**_____ **Amer. Indian**_____
Native Hawaiian/Other Pacific Islander_____ **Other** (fill in) _____

7. Child 4 Name: _____ _____ _____
Last First MI

Gender: (circle one) Male Female **Date of Birth:** _____/_____/_____ **Age**: _____

Health Conditions (circle all that apply) Speech Impairment Hearing Impairment Vision Impaired

Asthma Diabetes Hyperactivity Medications: _____

Allergies: _____ Other Illness: (explain) _____

Ethnicity: (you must check one) Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐

Race:(Check All that Apply: African American/Black_____ White_____ Asian_____ Alaskan Native_____ Amer. Indian____
Native Hawaiian/Other Pacific Islander_____ Other (fill in) _____

I have filled in the required above information, and guarantee that all information, to the best of my knowledge, is correct, concerning qualifications for this program. I understand and agree that my child can and will participate in all activities, and that non-participation in any activity is grounds for immediate exclusion and/or dismissal from the program.

_____ ____/____/____
PARENT SIGNATURE ***TODAY'S DATE***

8. AUTHORIZED ESCORTS (other than parents)

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

9. EMERGENCY CONTACTS (other than parents)

Name	Home Phone	Cell Phone	Work Phone
1. _____	_____	_____	_____
2. _____	_____	_____	_____

10. CM LEE CAMP EMERGENCY MEDICAL AUTHORIZATION, ACTIVITY RELEASE AND PUBLIC RELATIONS RELEASE

PLEASE COMPLETE

Physician and/or Clinic: Name:_____ **Phone Number:** _____

Dentist and/or Dental Clinic: Name:_____ **Phone Number:**_____

Medication Policy: Columbus Recreation and Parks Department staff shall not administer medication to participants of their programs. All medication taken by participant shall be self-administered, and no participant on medication shall be registered in the program unless that person is capable of taking his/her own medications, or parent/guardian is available to administer the medication. Recreation staff may (1) Remind a participant to take medication (2) Assist participant by taking the medication from the locked storage area and hand it to the participant. **Please identify type, dosage, and time for all medication that the participant is currently taking.**

Medication:_____ **Dosage:**_____**Frequency:** _____

Medical Authorization Policy: If attempts to contact me at the above listed phone numbers are unsuccessful, I authorize and give my consent for any emergency medical, surgical or dental treatment for my child (listed above) anywhere/anytime should it be deemed advisably by a qualified medical Doctor or Dentist, and the transportation of the child to the nearest hospital reasonably accessible. I understand this is to avoid undue delay and to assure prompt attention/treatment in an emergency. I hereby give permission to the City/CRPD to provide routine first aid care, administer prescribed medications in a life or death situation, and seek emergency medical treatment for my child when deemed necessary. In case of accident or injury, I will not hold the City of Columbus or its employees responsible. I understand and assume all risks that may occur during my child's participation in these programs. I understand that should any injury occur to my child at this camp, I will be responsible for all medical treatment and other costs through my medical insurance policy and/or personal finances.

Public Relations Policy: Please initial one of the following:

_____ **I authorize the City of Columbus to use my child's photograph/video for public relations purposes.**

-or-

_____ **I do not authorize the City of Columbus to use my child's photograph/video for public relations purposes.**

Date ____/____/____**Parent/Guardian Signature**_____